CITY OF LONG BEACH

Benefits Selection/Change/Delete Form

Complete and return this form to your department PPA. Refer to Employee Benefits Overview for plan options.

Employee Information

Name	Marital Status	Social Security Number
Contact Phone Number	Contact E-mail	Department

Employment Status:
☐**PF** (Full-Time) ☐**PP** (Part-Time) ☐**NC** (Non-Career)

Type of Action Requested based on Qualifying Event

Qualifying Event Date: _____

Qualifying Event: ☐**New Hire** ☐**Open Enrollment** ☐**Marriage** ☐**Divorce** ☐**Death** ☐**New Child** ☐**Loss of Other Coverage** ☐**Reduction in Hours** ☐**Child Support Order** ☐**Leave of Absence** ☐**Other:** _____

Enroll in Plan	**Cancel or Waive**	**Add/Delete Dependent**	**Change Plan**
☐Health PPO ☐Health HMO ☐Dental PPO ☐Dental HMO ☐Vision ☐FSA Health $ _____ ☐FSA Dependent Care $ _____	☐Health ☐Dental ☐Vision ☐FSA Dependent	☐Health ☐Dental ☐Vision	☐Health _____ ☐Dental _____ ☐FSA Dependent Care $ _____ ☐FSA Health $ _____

If you are adding or deleting a dependent due to a change in family status you may wish to update your beneficiary information. Please see your department PPA for instructions.

Please provide the annual FSA election amount(s).

☐**Dependent Name Change Only**

Dependent Information

Please make sure you have included the following copies, if applicable:

Spouse:	**Registered Domestic Partner:**	**Dependent Child:**
☐Marriage Certificate ☐Divorce Decree	☐Declaration of Domestic Partnership ☐Dissolution of Domestic Partnership	☐Birth Certificate ☐Adoption Certificate ☐Qualified Medical Child Support Order

Dependent Enrollment Selections

First Name	Last Name	SSN	Birthdate	Relationship

I acknowledge that the above information represents my enrollment choice(s). I understand that by signing this form I am electing to reduce my compensation in exchange for pre-tax health care coverage and I authorize payroll deductions for any required contribution. I understand my coverage elections cannot be changed until a future benefits enrollment period. I represent that to the best of my knowledge and belief, all statements and answers made on this form are true, complete and correct. If applicable, I hereby authorize any insurance company, hospital, physician or any other health care provider to release all information to all those who may have a bearing on benefits payable under this plan. Adjustments may be made to increase or decrease the amounts specified for deductions identified above by the City's Coding System, provided that the method, manner and amount of each such adjustment is in full compliance with the applicable laws or administrative rules and regulations of the City.

I understand that if my coverage is provided pursuant to an employer-sponsored benefit plan that it is exempt from ERISA or if I have a dispute that is not governed by ERISA that I will be subject to the following binding arbitration provision: If you are applying for coverage, please note that Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company require binding arbitration to settle all disputes including but not limited to disputes relating to the delivery of service under the plan/policy or any other issues related to the plan/policy and claims of medical malpractice, if the amount in dispute exceeds the jurisdictional limit of small claims court. It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. This means that you and Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company are waiving the right to a jury trial for both medical malpractice claims, and any other disputes including disputes relating to the delivery of service under the plan/policy or any other issues related to the plan/policy.

Signature: _____ Date: _____